

State of Montana
Clinical Eligibility Assessment for Mental Health Services Plan

Transmit the information below to AMDD Benefit Management Team

FAX: 1-406-444-4435

Phone: 1-406-444-3964

Mail: c/o AMDD

PO Box 202905

Helena MT 59620-2905

Please Type or Print:

CLIENT INFORMATION		
SSN:	DOB:	Gender:
Name: Last:	First:	Middle:
Mailing Address:		City:
County:	State: MT	Zip:
Telephone No:		
RESPONSIBLE PARTY INFORMATION, if other than client		
Name: Last:	First:	Middle:
Mailing Address:		
City:	State:	Zip:
Telephone No:	Relationship to client:	
PROVIDER INFORMATION		
Provider Name:		Provider No:
Address:		
City:	State:	Zip:
Telephone No:	Fax No:	
CLINICAL INFORMATION		
CURRENT DSM-IV DIAGNOSES:		
Please list code and narrative, including substance use disorders.		
Axis I : (Primary)		
Axis II:		
Axis III : (specify)		
Axis IV: (specify)		
Axis V: (GAF)		

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Name: Last _____ First: _____

SSN: _____

List Signs / Symptoms to Substantiate the Qualifying SDMI Primary Diagnosis:

Current Psychotropic Medications: Yes ☐ No ☐

Name of Medication:	Dose/Frequency

If none, has a medical professional with prescriptive authority determined that medication is necessary to control the symptoms of the mental illness?

Yes ☐ No ☐

Name and title of medical professional:

Has the individual been determined to be disabled due to mental illness by the Social Security Administration? Yes ☐ No ☐

History of Outpatient Mental Health Treatment: Yes ☐ No ☐

Please list any services in which the individual has participated, other than individual &/or family therapy.

History of Inpatient Mental Health Treatment: Yes ☐ No ☐

Number of Acute Admissions:

Date of most recent admission:

Number of Montana State Hospital Commitments:

Date of most recent commitment:

Has the individual participated in Substance Abuse/Dependency Treatment?

Yes ☐ No ☐

Provider, if known:

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Name: Last _____ First: _____
SSN: _____

Is the individual unable to work full-time because of mental illness? Yes ☐ No ☐

If yes, briefly describe:

Is the individual able to live independently? Yes ☐ No ☐

If not, briefly describe:

Is the individual homeless or at risk of homelessness? Yes ☐ No ☐

If yes, briefly describe:

Risk Factors:

(check all that apply)

Present

Past

Domestic Violence

☐☐

Suicidal Ideation

☐☐

Sexual Abuse

☐☐

Eating Disorder

☐☐

Evidence of Psychosis

☐☐

Threat to Others (homicidal ideation)

☐☐

"I certify that I am the person who performed face-to face clinical assessment and the above statements are true and current."

Provider Signature: _____ Title: _____

Printed Name: _____ Date: _____

Supervisor Signature: _____ Date: _____
(if applicable)

Addictive & Mental Disorders Division Use Only:

Reviewed By: _____ Date: _____

SDMI: APPROVED: _____ DENIED: _____